AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT PHOTOGRAPHIC IMAGES

I, _____authorize A Brighter Smile Family and Cosmetic Dentistry to take photographic/ video images, and/or testimonial for marking purposes. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations. I authorize before and after pictures of the Zoom whitening, Crowns, Veneers, and Fillings to be marketed on:

(Please initial all that apply):

_____A Brighter Smile website.

_____A Brighter Smile Social Media.

_____A Brighter Smile billboards or promotional material.

I hereby release and discharge A Brighter Smile Family and Cosmetic Dentistry and all persons functioning under her permission or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, Invasion of privacy or any claims based on the production or the process of recording or publishing the material.

I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail or email. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

I give my consent to the following:

_____Teeth only can be shown.

_____Full portrait can be shown.

_____First name CAN be used.

_____Please check here if you do not wish to be photographed.

Date_____

Print Full Name of Patient_____

Signature of Patient/Parent of Minor_____

We are on Facebook!!! ___Check here if you would like us to follow you on Facebook please.